Wellness-at-Work Survey

This survey is designed to help the Rhode Island Department of Health Wellness Team determine your health interests and needs. We will be working with your employers to improve wellness practices in your workplace. By completing this survey, you will help our wellness team to offer appropriate programs at convenient times for you and your coworkers. **Please remember that you are not required to answer all questions and that this survey is entirely anonymous**. Thank you, in advance, for all of your cooperation. We look forward to helping you create a positive health-conscious environment for you and your coworkers!

Demographic Information

What is your gender?

- □ Male
- □ Female

What is your race?

- □ White
- □ African American
- □ Asian
- □ Native Hawaiian or Pacific Islander
- □ American Indian or Alaska Native
- □ Other_____

How old are you?

- □ <20 years
- □ 20-29 years
- □ 30-39 years
- □ 40-49 years
- □ 50-59 years
- □ 60+ years

Do you have children living at home?

- □ Yes, _____(Number of children)
- □ No

If you have children living at home, how old are they? (Check all that apply)

- □ 0-5 years
- □ 6-10 years
- □ 11-15 years
- □ 16+ years

Do you care for an elderly parent or relative?

- □ Yes
- □ No

Do you live in Rhode Island?

- □ No
- □ Yes, in _____(City)

Overall, how would you categorize your current health status?

- □ Excellent
- □ Very good
- □ Good
- □ Fair
- □ Poor

What would you like to improve about your current health status?

_____

_____

Tobacco Use

Do you smoke tobacco?

- □ Yes
- □ No

Do you use other tobacco products? (Chew/snuff, etc.)

- □ Yes
- □ No

Have you ever participated in a quit smoking program?

- □ Yes, and it helped me to quit permanently
- □ Yes, but I still smoke
- □ No, never have

Would you like information on how to quit smoking?

- □ Yes
- □ No

If so, what types of information would you prefer?

- □ Group classes
- □ Telephonic assistance
- □ Written literature
- □ Other_____

Physical Activity

When you are at work, which of the following *best* describes what you do?

- □ Mostly sitting or standing
- □ Mostly walking
- □ Mostly heavy labor or physically demanding work

How often do you exercise? (Not including labor for work)

- □ Never
- □ A few times per month
- □ A few times per week
- □ Almost every day

How long do you spend exercising each time?

- □ 0-10 minutes
- □ 10-20 minutes
- □ 20-30 minutes
- □ 30+ minutes

What type of exercise do you engage in? (Check all that apply)

- □ Walking
- □ Biking
- □ Jogging/Running
- □ Aerobics/Yoga/Pilates
- □ Weight lifting
- □ Swimming
- □ Other_____

Nutrition

Please indicate how often in *one week* that you do the following.

Eat five or more servings of fruits and vegetables:

- □ No days
- □ 1-2 days
- □ 3-4 days
- □ 5-6 days
- □ Everyday

Eat food not prepared at home such as fast food, take out, or sit-down restaurants:

- □ No days
- □ 1-2 days
- □ 3-4 days
- □ 5-6 days
- □ Everyday

Drink one or more beverages sweetened with sugar such as sweetened juices or regular soda:

- □ No days
- □ 1-2 days
- □ 3-4 days
- □ 5-6 days
- □ Everyday

What are your barriers to not eating healthy? (Check all that apply)

- □ No time to cook
- □ Don't know how to cook healthy meals
- □ Can't tell what is healthy when dining out
- □ Don't like the taste of fruits or vegetables
- □ Can't afford it
- □ Other_____

Sleep

Do you often have trouble sleeping? (Falling asleep, staying asleep, etc.)

- □ Yes
- □ No

Do you often feel tired throughout the day?

- □ Yes
- □ No

Screenings

Please indicate which services and screenings you have received in the past **12 months.**

Screenings & Services	Yes	No
Blood Pressure Check		
Cholesterol Screening		
Glucose Screening		
Body Composition/BMI Screening		
Bone Density Screening		
Dermascan (Sun Safety) Screening		
Influenza Immunization		
Annual Visit to Primary Care Physician		

Interests

Please indicate how likely you would be to attend one of these **free** programs if they were offered in your workplace.

Programs and Screenings	Yes, definitely would attend	Might attend	No, would not attend
Blood Pressure			
Body Composition			
Glucose			
Cholesterol			
Immunizations			
Back Safety			
Chronic Disease Prevention (Cancer, Heart Disease, Diabetes)			
Chronic Disease Self-Management			
Home Safety (Radon, Lead, Carbon Monoxide)			
Smoking Cessation			
Stress Management			
Financial Management			
Sleeping			

Programs and Screenings	Yes, definitely would attend	Might attend	No, would not attend
Parenting			
Breastfeeding/New Mothers			
Weight Management			
Healthy Eating			
On-site Exercise Programs			
Walking Clubs			

Timing of Programs

Please indicate how likely you would be to attend a program offered at the specific time.

Before Work
- □ Yes, definitely would attend
- □ Might attend
- □ No, would not attend

During Lunch/At Work
- □ Yes, definitely would attend
- □ Might attend
- □ No, would not attend

After Work
- □ Yes, definitely would attend
- □ Might attend
- □ No, would not attend

Would you attend programs off-site, such as those offered at a community center?
- □ Yes, definitely would attend
- □ Might attend
- □ No, would not attend

Please list any and all comments or suggestions you may have regarding current or future wellness programs at your company.

_____
_____
_____
_____
_____
_____
_____.